PRINTED: 08/15/2011 FORM APPROVED

ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 155717	A. BUILDING B. WING	COMPLETED 08/03/2011				

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC INDIANAPOLIS, IN46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0000 F0000 This visit was for the Investigation of Complaint IN00093072 and Complaint IN00094211. Complaint IN00093072-Unsubstantiated, due to lack of evidence. Complaint IN00094211- Substantiated, Federal/State deficiencies related to the allegation is cited at F240 and F242. Survey dates: August 2 & 3, 2011 Facility number: 000376 Provider number: 155717 AIM number: 100275510 Survey team: Rita Mullen, RN, TC Census bed type: SNF/NF: 60 Total: 60 Census payor type: Medicare: 8 Medicaid: 48 Other: Total: 60 Sample: 4

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Supplemental sample: 7

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

X9VR11

Facility ID:

000376

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 08/03/2011			
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC			2640 C	ADDRESS, CITY, STATE, ZIP CODE OLD SPRING RD APOLIS, IN46222	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) These deficiencies also reflect State findings cited in accordance with 410 IAC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	16.2. Quality review conditions 2011 by Bev Fau	ompleted on August 8, lkner, RN.			
F0240 SS=D			F0240	F- 240 Residents Right to Choose: The Alpha Home under resid right and rights as citizen fully ensure residents have the right choose their and make their decisions with resident's preferences. Corrective Action Related to Finding: The Alpha Home has update policy for resident's choices with the council president had an executive resident council meeting to express and emphasize the right to decisional making for morning get up tire and decisions for resident right rights are sident." S. B., D. E., &I have a been interviewed with their council plans revised and reflect the	y yht to own This d its with ent on mes hts. all

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
		155717	B. WIN			08/03/2	011
			D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	S.			OLD SPRING RD		
	HOME ASSOC OF G	GREATER INDIANAPOLIS INC			APOLIS, IN46222		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
	dress for the day	. Resident I preferred to			resident choices for a prefer		
	sleep longer.			get up time. Resident's family members and POA where			
					contacted for residents not a	ble to	
	During an interv	iew with Resident G, on			verbally communicate their	2.0 10	
	8/3/11 at 1:30 P.1	M., she indicated that her			choices.		
		otten at 4:00 A.M. daily					
	· ·	red her when they get her			The Alpha Home morning	4:£:	
		eaned and dressed that			residents get up list and (cer nursing assistant) assignmen		
	_	G did not want to be			sheets now have the preferre		
	awakened that ea				time for resident's choices to		
	awakenea mat et	шту.			residents up in the morning.		
	During an interview with Resident J, on				DON has approved the prefe		
		•			times and the unit manager I		
		A.M., it was indicated			placed and posted the prefer time of the residents. The	reu	
	_	ten up early and they			Customer Service focus for		
		g around in the Activities			satisfaction shall be reviewed		
	room or TV room	n.			each morning at the manage		
					meeting. The Director of Nur		
	During an intervi	iew with Resident L, on			has in serviced the staff with changes.		
	8/2/11 at 2:00 P.I	M., it was indicated			changes.		
	residents are gott	ten up early at about 4:00			Residents with Potential to b	<u>oe</u>	
	A.M. and they ju	st leave them sitting.			affected by this finding will be	<u>e_</u>	
					identified by:		
	A review of the s	staff scheduling, dated			Other residents having the potential to be affected by th	ese	
	7/1/11, indicated	the nightshift was from			findings are identified by:		
	11:00 P.M. to 7:3	30 A.M.			Residents listed on the morn	ing	
					get up sheet, resident	-	
	A review of the "Get up list," dated 8/2/11, indicated 24 Residents that were to be gotten up by the nightshift and instructed if a resident refuses to get up				participation in the emergend		
					resident council meeting, and communication sent to the fa		
					council, guardians and POA.		
					Review of residents regular		
		port to the nurse and find			scheduled care plans will allo		
	an alternative res				for the residents preferences		
	an ancinative les	sident to get up.			be documented with preferen		
	D				and changes. The facility has established a communication		
	During an interv	iew with LPN #1 on			Cotabilorieu a Communication	1	

B. WING	2011
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN46222	
ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC (X4) ID SIMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 8/2/11 at 1:00 P.M., she indicated that they start getting residents up around 5:00 A.M., and that it was nightshift's job to get those residents on the "Get up list" up and dressed for the day. This Federal tag relates to Complaint number IN00094211. 3.1-32(a) 3.1-32(a) 1. Daily review and resident satisfaction for preferences presented at the morning manager meeting. 2. Daily input and correction for residents that have more than one preference in their choices as residents. 3. Tracking audits reviewed by the Director of Nurses and monitored by the unit manager presented at the manager presented at the manager presented at the manager presented at the manager presented to the unit manager presented to guality assurance committee. 5. Staff assignment sheets have been reassigned per the president's choice and preference. 6. SSD interviewed resident's roommate to ensure their choice of not being disturbed is included. 7. Completed. 8. Activity calendar now identifies the early morning activity.	(X5) COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/03/2011		
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Actions will be monitored to Ensure Compliance by: Staff who violated the faculty policy on resident's choices receive the facility corrective action plan. Repeat violators subject to the Alpha Home disciplinary policy which incl suspension and/and or termination. There will be a weekly review compliance with the IDT utility the audit sheets. These wee audit sheets and compliance sheets are collected and review for distribution at the Quality assurance meeting; The Quassurance committee will momonthly and make a determination to continue monitoring based on compliance accuracy and successful residents satisfaction for right and preferences. Compliance. The Quality Assurance for monitoring is the next three months. Upon review by the Quality assurance committee a determination she made to continue the audit provide an additional course action. Completion Date: August 22, 2011.	shall be ude w of zing kly eliew ality conitor ance, nts for nce hall lits or		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155717 08/03/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2640 COLD SPRING RD ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC INDIANAPOLIS, IN46222 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The resident has the right to choose activities, F0242 schedules, and health care consistent with his SS=E or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. F- 242 Residents Right to Based on interview and record review, the F0242 08/11/2011 Choose: facility failed to ensure residents were The Alpha Home under residents given the right to choose their schedules right and rights as citizen fully or preference for residents on the "Get up ensure residents have the right to choose their and make their own list" who are gotten up early in the decisions with resident's morning by the nightshift. There was no preferences. indication the residents' usual time of rising before coming to the facility was Corrective Action Related to This Finding: considered. This actually impacted 3 of 4 residents reviewed for preferences The Alpha Home has updated its regarding what time they would prefer to policy for resident's choices with get up in the morning in a sample of 4 and decision-making. The Resident had the potential to affect all residents on Council president had an executive resident council the "Get Up list." The current list meeting to express and indicated 24 of 60 residents were on the emphasize the right to decision "Get up" list. (Residents B, D and E) making for morning get up times and decisions for resident rights. Resident:"s I, G, J, and L have all Findings include: been interviewed with their care plans revised and reflect the The clinical record of Resident B was resident choices for a preferred reviewed on 8/2/11 at 10:00 A.M. get up time. Resident's family members and POA where Diagnoses for Resident B included, but contacted for residents not able to were not limited to, dementia and verbally communicate their diabetes. Resident B was on the "Get up choices. list" and it was indicated during the The Alpha Home morning facility tour with LPN #1, on 8/2/11 at residents get up list and (certified 8:45 A.M., that Resident B was not nursing assistant) assignment interviewable. There was no preference sheets now have the preferred

000376

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED	
		155717	B. WIN			08/03/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				1	OLD SPRING RD	
ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC				1	IAPOLIS, IN46222	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		chart, as to what time the			time for resident's choices to residents up in the morning.	
	_	refer to get up in the			DON has approved the prefe	
	"	time the resident was			times and the unit manager	
	used to getting u	p before coming to the			placed and posted the prefe	rred
	facility.				time of the residents. The	
					Customer Service focus for	
	The clinical reco	rd of Resident D was			satisfaction shall be reviewe each morning at the manage	l l
	reviewed on 8/3/	11 at 11:05 A.M.			meeting. The Director of Nur	
		esident D included, but			has in serviced the staff with	l l
	were not limited				changes.	
	schizophrenic traits, dementia and severe				Desidents with Detential to	
	_	nt D was on the "Get up			Residents with Potential to I affected by this finding will be	
	_	ndicated during the			identified by:	<u>-</u>
		LPN #1, on 8/2/11 at			Other residents having the	
	1 *				potential to be affected by th	ese
	· ·	Resident D was not			findings are identified by:	
		here was no preference			Residents listed on the morr	ing
		chart, as to what time the			get up sheet, resident	
	_	refer to get up in the			participation in the emergend resident council meeting, an	- 1
	morning or what	time the resident was			communication sent to the fa	
	used to getting u	p before coming to the			council, guardians and POA	
	facility.				Review of residents regular	
	-				scheduled care plans will all	
	The clinical reco	rd of Resident E was			for the residents preferences	l l
	reviewed on 8/3/				be documented with prefere and changes. The facility ha	l l
		esident E included, but			established a communication	
	~	•			quality indicator correction si	
	were not limited to, senile delusions, Alzheimer's Disease and depression.				for resident s choices; this sl	
					is reviewed weekly and pres	
	Resident E was on the "Get up list" and it				monthly to the quality assura	nce
	was indicated during the facility tour with LPN #1, on 8/2/11 at 8:45 A.M., that				committee.	
					III. Measures and Systemic	
		not interviewable. There			Changes put into Place to As	ssure
	was no preference	e indicated in the chart as			Deficit Practices do not recu	
	to what time the	resident would prefer to			as Follows:	
	get up in the mor	rning or what time the				
	1 oct up in the moi	or much time the			l .	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMPLETE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	155717	A. BUILDING	00	08/03/2011	
1007.17			B. WING	ADDRESS OF A STATE OF SORE	00/00/2011	
NAME OF PROVIDER OR SUPPLIER			l l	ADDRESS, CITY, STATE, ZIP CODE		
ALPHA F	HOME ASSOC OF G	REATER INDIANAPOLIS INC	l l	NAPOLIS, IN46222		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		d to getting up before		Daily review and reside satisfaction for preferences	nt	
	coming to the fac	cility		satisfaction for preferences presented at the morning		
				manager meeting.		
	_	iew with Resident I, on		Daily input and correction		
		M., it was indicated that		residents that have more that	ı	
	I -	en up for the day, on the		one preference in their choic residents.	es as	
	"	at her roommate was		Tracking audits reviewer	ed by	
	1	at about 6:00 A.M., each		the Director of Nurses and		
	•	lidn't want to get up.		monitored by the unit manager's	er	
	Resident I was awaken when her roommate was gotten up, cleaned and dress for the day. Resident I preferred to			presented at the manager's meeting		
				4. Weekly audits analyzed	l and	
				presented to quality assuran		
	sleep longer.			committee for compliance.		
				5. Staff assignment sheets have been reassigned per th		
	During an intervi	iew with Resident G, on		resident's choice and preference.		
	8/3/11 at 1:30 P.I	M., it was indicated that		6. SSD interviewed reside		
		as gotten at 4:00 A.M.		roommate to ensure their ch	ı	
	•	oothered her when they		of not being disturbed is included. 7. Consent forms for chan		
	-	e up, cleaned and dressed		preference with getting up	gc	
	1 1	ent G did not want to be		completed.		
	awakened that ea	rly.		8. Activity calendar now		
				identifies the early morning activity.		
	~	iew with Resident J, on		activity.		
	8/2/11 at 10:00 A	A.M., it was indicated				
		en up early and they		Actions will be monitored to		
	l .	g around in the Activities		Ensure Compliance by: Staff who violated the faculty	r'e	
	room or TV roon	1.		policy on resident's choices		
				receive the facility corrective		
	~	iew with Resident L, on		action plan. Repeat violators	<u>be</u>	
		M., it was indicated		subject to the Alpha Home disciplinary policy which includes	ıde	
		en up early at about 4:00		suspension and/and or	uuc_	
	A.M., and they ju	ast leave them sitting.		termination.		
				There will be a weekly review		
	A Meal Time sch	edule, received from the		compliance with the IDT utilize	<u>zing</u>	

	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/03/2	ETED
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC			p. wirk	STREET A	OLD SPRING RD APOLIS, IN46222	1	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR Director of Nurs: P.M., indicated by 7:30 P.M. A review of the service	tatement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ing, on 8/2/11 at 1:00 breakfast was served at staff scheduling, dated the nightshift was from 30 A.M. and three CNAs cheduled to care for 60 included getting up the 'Get up list." Activities Schedules for ugust, 2011, indicated acility start at 9:30 A.M. CNA (Certified Nursing ments sheets, dated d the residents on the Get up list," dated 24 residents that were to the nightshift and if a to get up the CNA is to the and find an alternative of the control o		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) the audit sheets. These were audit sheets and compliance sheets are collected and revious for distribution at the Quality assurance meeting; The Quassurance committee will memority and make a determination to continue monitoring based on compliance accuracy and successful residents satisfaction for riginal and preferences. Compliance. The Quality Assurance for monitoring is the next three months. Upon review by the Quality assurance committee a determination is be made to continue the audit provide an additional course action. Completion Date: August 22, 2011.	kly e iew ality onitor ance, that	(X5) COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2011 FORM APPROVED OMB NO. 0938-0391

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CO A. BUILDING B. WING	00	I	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC		2640 C	ADDRESS, CITY, STATE, ZIP CO OLD SPRING RD IAPOLIS, IN46222	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	This Federal tag number IN00094 3.1-3 (u)(1) 3.1-3(u)(3)	relates to Complaint 1211.				

000376